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Review Group

on

Physical and Sensory Disability

Interim Report to the Minister for Health

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Review Group on Physical & Sensory Disability

c/o Department of Health, Room 407, Hawkins House, Dublin 2.

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31 January, 1992.

Mr Brendan Howlin T.D.
Minister for Health
Hawkins House
Dublin 2

Dear Minister

I have pleasure in submitting to you the Interim Report of the Review Group on Services for People with a Physical or Sensory Disability.

We were established by your predecessor, Dr John O'Connell, who asked the Group to prepare an Interim Report on the most urgent needs so that these could be considered in the context of developments under the Programme for Economic and Social Progress in 1993.

The Interim Report is presented on this basis. It identifes urgently required service developments costing £5.63m which can be put in place quickly. We are satisfied that implementation of our recommendations will lay a sound foundation for the further development of services.

As indicated in the Report, we do not attempt to define long-term policy and service needs of people with physical or sensory disability. This will form the basis of our final report which we hope to submit to you as soon as possible.

Yours sincerely

T Mooney

Tom Mooney
Chairman

Contents

Summary of Recommendations

1. The present home-help service should, as an initial step, be expanded to cater for an additional 500 - 600 people with physical and sensory disability. (3.4)

2. Home care assistance schemes should be expanded to provide assistance to approximately 200 disabled people and their families. (3.5)

3. A sum of £50,000 should be set aside to enable health boards and voluntary bodies to provide flexible home supports which can respond in a non-structured way to meet special needs. (3.6)

4. As an interim measure, pending the report of the Special Education Review Committee, additional support services for children in full-time education should be provided through the health boards. (3.7)

5. Additional capital resources of £500,000 should be provided in 1993 to enable building work to proceed on a number of day care/therapy centres. (3.11)

6. Additional funding of £250,000 should be provided to enable existing day care centres to open for extended periods and to adapt other premises in the community for use as day care centres. (3.12)

7. As an immediate step towards meeting the need for respite care places, health boards should arrange for the provision of respite care places in nursing homes or other suitable locations. (3.15)

8. As an initial step, 50 community based therapists in the different disciplines (physiotherapy, occupational therapy and speech therapy) should be recruited immediately. (3.20)

9. An additional sum of £250,000 should be made available on an ongoing basis to improve the availability of technical aids and appliances. (3.21)

10. In order to meet the immediate need for residential facilities and pending the availability of purpose-built accommodation, health boards should examine the possibility of providing residential accommodation in specially dedicated units at existing hospitals. The question of placements in suitable nursing homes should also be examined. (3.25)

11. Additional revenue funding of £150,000 should be provided in 1993 to facilitate the opening of new residential developments at Sligo and Letterkenny. (3.26)

12. A sum of £1m should be made available to redress the current funding deficits, staffing shortages and disparity in pay rates in the voluntary sector. (3.29)

13. Additional sign language interpreters should be trained. (3.30)

14. Additional funding of £30,000 should be made available to expand driver training. (3.31)

15. The Motorised Transport Grant should be increased to £2,500. (3.32)

16. The recommendations of the Commission on Social Welfare, subsequently endorsed by the Commission on Health Funding, in regard to the transfer of income maintenance schemes for people with disabilities

to the Department of Social Welfare should be implemented as a matter of urgency. (3.34) . .

17. Planning of at least four 20-place residential care units should commence in 1993. (4.6)

18. Planning should also commence immediately on four 10-place respite care centres. (4.7)

19. The provision and funding of sheltered work/employment should be the subject of a separate examination as a matter of urgency. (4.9)

Chapter I

Introduction

Establishment and Terms of Reference

1.1 We were established by the Minister for Health on 30th June 1992. Our terms of reference are:-

> *To examine the current provision of health care services to people with physical or sensory disabilities and to consider how they should be developed to meet more effectively their needs and specifically to make recommendations for service developments in accordance with the commitment contained in Section IV, Paragraph 33 of the Programme for Economic and Social Progress.*

1.2 Section IV, Paragraph 33 of the Programme for Economic and Social Progress states that:-

> *"Services for people with physical disabilities will continue to be expanded by the provision of community-based support services. Priority support services will be:*
>
> - *provision of additional paramedical services, i.e. physiotherapy, speech therapy, occupational therapy;*
> - *provision of additional day care centres;*
> - *provision of respite care facilities;*
> - *provision of additional home support services, and*
> - *new training workshops and improvement of existing facilities.*
>
> *A number of additional residential places for physically disabled people will also be provided."*

1.3 The terms of reference given to us by the Minister relate specifically to the provision of health care services to people with physical or sensory disability. We are aware that other aspects of services for people with physical disabilities are currently being examined or are the subject of on-going review. These include -

(a) the Inter-Departmental Committee on Transport for mobility impaired persons,

(b) the National Rehabilitation Board's Advisory Committee on Training and Employment of people with disabilities,

(c) the Review Group on Special Education and

(d) the examination currently being undertaken, in accordance with paragraph 120, section IV of the Programme for Economic and Social Progress, on how best the rights of people with disabilities can be promoted.

While our remit only relates to health services, it is our intention to draw attention to situations which create barriers to access to health services and to any deficiencies in other services which create additional demands for health care services.

Membership

1.4 The membership of the Group is as follows:-

Mr Tom Mooney	Chairman, Department of Health,
Mr Paul Barron	Principal Officer, Department of Health
Mr Michael Bruton	Programme Manager, Community Care, Western Health Board

Dr Pauline Faughnan	Social Science Research Centre, University College Dublin
Mr P J Fitzpatrick	Programme Manager, Hospital Services, Midland Health Board
Dr Thomas Gregg	Chairman, Cerebral Palsy Ireland
Mr Liam Hughes	Assistant Principal Officer, Department of Education
Mr Niall Keane	Chief Executive, National Association for the Deaf
Mr Des Kenny	Chief Executive, National Council for the Blind of Ireland
Ms Angela Kerins	Summerhill Road, Dunboyne, Co Meath
Dr Jim Kiely	Medical Officer, Department of Health
Mr Brendan Ingoldsby	Director, Multiple Sclerosis Society of Ireland
Ms Mary Murphy	Trim, Co Meath
Dr Arthur O'Reilly	Chief Executive, National Rehabilitation Board
Mr Donal Toolan	Forum of People with Disabilities
Ms Anne Winslow	Director of Services, Irish Wheelchair Association
Mr Brian Mullen	Assistant Principal Officer, Department of Health (Secretary)

1.5 Following an initial examination of our remit we have established working groups to examine three key issues which we identified as crucial to our deliberations. These are

(a) the development of information systems on the numbers and service needs of physically disabled people which are required to facilitate the planning and delivery of services,

(b) an examination of current service provision to identify gaps and to make recommendations for development, and

(c) the organisation and co-ordination of services to ensure the effective and efficient delivery of services.

Interim Report

1.6 In his address to the inaugural meeting, the Minister for Health requested us to prepare a comprehensive report which would provide a blueprint for the development of health care services for people with physical and sensory disabilities for the next decade and beyond. The Minister stressed that he wanted us to complete our task in the shortest possible time. However, he recognised that it would take some time to complete a full examination of our remit and requested an Interim Report by the end of 1992 on the most urgent needs so that these could be considered in the context of developments under the Programme for Economic and Social Progress in 1993.

1.7 Having regard to the Minister's request, this Interim Report is confined to an examination of services to meet urgent needs which can be put in place in 1993. While we have outlined some broad principles which should underpin the development of services, we do not, in this Interim Report, attempt to define long-term service needs of people with physical or sensory disability. We will consider these in our final report. We see our task in this Interim Report as twofold, namely

(a) identifying services and initiatives which would meet urgent needs of people with physical or sensory disability and which could be put in place in the short-term, and

(b) identifying needs which, although urgent, cannot be met in the short-term but on which planning should commence immediately.

1.8 In preparing this report we also have had regard to submissions received to date. Appendix II contains a list of bodies who were invited to make submissions. We have found these submissions most helpful and they will be examined in depth as part of our task of preparing our final report.

Chapter II

General Considerations

2.1 In our view the underlying philosophy governing the provision of health services should be to enable people with physical or sensory disability to be as self-reliant and independent as possible and to facilitate their integration in all aspects of community life. We are satisfied that the provision of community based services and facilities, along the lines suggested in the Programme for Economic and Social Progress, will contribute significantly to achieving this objective.

2.2 The prevention of disability is a primary aim of the health services. We will consider this and related issues in detail in our final report including the need for health education, road safety, safety at work and in the home, adequate genetic counselling, early identification, effective early treatment and rehabilitation services.

2.3 We are strongly of the view that in the development of services priority should be given to the provision of primary care support services such as home/personal care, day care etc, which will enable people to live as independently as possible in the community. Equally important however is the provision of support to those caring for people with disabilities in their homes. Experience in the mental handicap service and elsewhere has shown that where adequate community support services for people with disabilities and their carers are provided, the demand for secondary support services such as respite and residential care is considerably reduced.

2.4 At present comprehensive information on the numbers and service needs of physically disabled people is not readily available. The following figures represent the numbers of such persons known to organisations working in the field of physical disability:-

Cerebral Palsy	9,000
Spina Bifida	1,500
Multiple Sclerosis	4,000
Friedreich's Ataxia	150
Muscular Dystrophy	210
Motor Neurone	270
Visual Impairement	7,100
Hearing Impairment	3,500
Cystic Fibrosis	800
Epilepsy	20,000
TOTAL	46,530

2.5 The development of an information database to assist the planning of services is one of the crucial areas which is being addressed by the Group. Such information, when available, will facilitate not merely more precise estimates of need, but also the definition and evaluation of objectives, the attainment of standards and their financial requirements.

2.6 On the basis of information currently available and from surveys carried out we are satisfied that there are substantial deficits in the level of services for people with physical or sensory disabilities and that the co-ordination and integration of existing services needs to be improved. As outlined in paragraph 1.2, the Programme for Economic and Social Progress provides for additional resources to be made available for the development of community based services. We note with concern that of all the health services for which development monies were promised under PESP, services for people with physical and sensory disability constitute the only area for which no additional resources have to date been provided.

2.7 There is evidence of an uneven provision of services both in terms of geographic spread and in the level of provision for different disability groups. This necessitates some people having to travel long distances to avail of services

such as physiotherapy or occupational therapy which can cause considerable hardship to both the disabled person and his/her family. In the provision of new or extended services recommended in this report priority should be given to areas where currently none exist. Through the provision of practical supports, much can be done in the short-term to improve substantially the quality of life of people with physical and sensory disabilities and their families whose currently perceived needs, in the absence of adequate primary care services, probably exceed actual needs.

2.8 Services for people with physical or sensory disabilities are currently provided by a mix of statutory and voluntary bodies. We are conscious of the significant contribution which voluntary bodies have made to the development of services, particularly community based services and residential care facilities. They provide substantial funding and a dedicated pool of volunteers to supplement the restricted resource availability. We see a strengthened and co-ordinated voluntary sector continuing to play an important role in the future.

2.9 The organisation of services at both national and local level in a co-ordinated manner is an issue which will be addressed in detail in our final report. In the meantime we recommend that immediate consideration be given in each health board area as to how services can be better integrated and co-ordinated.

2.10 We consider that in the provision of health and social services generally there is a need to take greater account of the needs of people with physical or sensory disability. An obvious example of this is the provision of day care centres for the elderly. There are some elderly people with disabilities who should more appropriately be availing of an integrated day care service in their local community but who, because of problems of access etc, are receiving no service or have to travel a considerable distance to a facility catering specifically for people with disabilities. The existing infrastructure should therefore be examined to see if it can be adapted or modified to facilitate use by people with a physical or sensory disability.

2.11 There is an essential and urgent need to strengthen and broaden the scope of services available so that they can meet essential needs. In considering our approach, we have had regard to providing the most appropriate response to client needs and the speed of implementation. The areas of care and support identified in Chapter III as requiring immediate action are an integral part of our long-term vision of service structuring and orientation. The principle of independent living to the greatest extent possible is the agreed objective.

Chapter III

Urgent needs capable of being met immediately

3.1 As indicated in Paragraph 1.7 our approach to identifying urgent needs has been firstly, to identify services which can be put in place quickly that will make a significant and speedy improvement to the lives of people with physical and sensory disabilities and secondly, to indicate services which need to be developed but because of the time required for planning and construction cannot be brought on stream in the short-term. We deal with the latter category in Chapter IV.

3.2 We have identified the following areas which are capable of being provided quickly and which will address urgent deficits in current service provision.

Home Support Services

3.3 In most cases people with physical and sensory disabilities rely on their families to provide day-to-day assistance in meeting their personal needs. Clearly this puts considerable strain on many families, particularly where parents or relatives are elderly. The existing home-help and public health nursing services are aimed primarily at elderly people and only provide limited assistance to people with physical and sensory disabilities. The following table outlines the position in relation to the home-help service.

Home-Help Statistics 1990 (Source: Dept. of Health)

HEALTH BOARD	TOTAL NO'S	ELDERLY		PHYSICAL DISABILITY	
		NO'S	% OF TOTAL	NO'S	% OF TOTAL
EASTERN	4,977	3,765	75.65%	559	11.23%
MIDLAND	1,097	716	65.27%	191	17.41%
MID-WESTERN	1,383	1,040	75.20%	114	8.24%
NORTH-EASTERN	1,221	1,080	88.45%	64	5.24%
NORTH-WESTERN	1,023	842	82.31%	72	7.04%
SOUTH-EASTERN	1,113	981	88.14%	55	4.94%
SOUTHERN	2,394	2,051	85.67%	76	3.17%
WESTERN	1,848	1,599	86.53%	103	5.57%
TOTALS	15,056	12,074	80.19%	1,234	8.20%

3.4 We recommend that the present home-help service be extended to provide services to more people with physical or sensory disability. Precise needs in this area can only be established when there is a full assessment of need available, but as an initial step we recommend that services should be expanded to cover an additional 500 - 600 persons with a physical or sensory disability at an estimated cost of £500,000 in a full year.

3.5 A number of voluntary organisations have developed home care assistance schemes which provide a flexible approach to the care of people with disabilities. Such schemes operate by providing the disabled person with assistance at night, weekends etc. In limited cases ongoing care is provided to, for example, persons in full time education. We are satisfied that there is an urgent need to develop such schemes and recommend that as a first step, arrangements be made to provide such a service to an additional 200 people and their families. The full year cost of providing this service is estimated at £500,000.

3.6 We recommend that a further £50,000 be set aside to enable health boards and voluntary bodies to provide flexible home supports which can respond in a non-structured way to meet the special needs of some people with physical or sensory disability. This service would assist, as a matter of priority, those who are on waiting lists and who currently are not in receipt of any service or are receiving a service which is not adequate to meet their needs. The support could be provided in a number of ways depending on the individual needs of the person with a disability or his/her family. The support could range from home care and nursing assistance to a more concentrated service during, for example, periods of domestic crisis. The main aim of the service would be to provide a flexible means of assisting families to cope with the burden of caring for a person with a disability in the home.

School Support

3.7 The general issue of the supports to be provided for children with

disabilities in an educational context, including those with a physical or sensory disability, is being addressed by the Special Education Review Committee. However, in view of the difficulties currently being experienced by many such children in relation to their personal care, an interim measure is considered essential. Accordingly, we recommend the immediate provision of additional child care support services through the health boards. We estimate that a sum of £100,000 would provide support for approximately 150 children.

Day Care

3.8 Day care and day activity centres fulfil a dual purpose by providing a satisfying alternative for people who are unable to work and also affording respite to carers. The activities at these centres are varied and may include physical, social, educational and recreational activities. In addition, staff may assist with personal needs.

3.9 There is an uneven distribution of day care centres throughout the country with a particular shortage of centres for people with physical disabilities. The following table illustrates this:

Day Centres by category and health board area - June 1990

Health Board	MH	MI	PH	Multiple	Elderly	Total
Eastern	21	21	12	3	40	97
South Eastern	3	0	0	4	16	23
Southern	4	7	2	3	70	86
Mid-Western	1	6	1	1	6	15
Midland	6	6	0	3	9	24
North-Eastern	2	5	0	2	17	26
North-Western	9	7	1	6	30	53
Western	17	19	0	3	36	75
Total	**63**	**71**	**16**	**25**	**224**	**399**
% of Total	**16%**	**18%**	**4%**	**6%**	**56%**	**100%**

MH Mental Handicap **MI** Mental Illness **PH** Physical Handicap **Multiple** Multiple Handicap

3.10 While the above table shows some areas without a specific day care service for people with physical or sensory disability, in many instances a service is available in centres not specifically catering for people with physical

or sensory disability. However the overall picture is less than satisfactory in respect of the provision for people with physical disabilities.

3.11 We are aware that there are a number of centres in planning which will provide a mixture of pre-school, therapy, day activity and sheltered work. Additional capital will be required to enable these to proceed in 1993. We recommend that a capital investment of £500,000 be set aside in 1993. Revenue costs on these developments will not arise until 1994.

3.12 We understand that, in many cases, existing day care centres are not operating to full capacity through lack of adequate resources. Additional funding would enable these to open for extended periods, i.e. in the evenings and at week-ends and so provide a more flexible response to the needs of clients. This would have the added advantage of making fuller use of the transport currently available. There are a range of other premises in the community which could, with minimal adaptation, be used to house a day care facility e.g. community centres, youth clubs, sports halls. Location of day centres at such premises should be examined as a matter of urgency. We recommend that additional resources of £250,000 be made available to facilitate such developments.

Residential Respite Care

3.13 Respite care or crisis intervention has an invaluable role to play in helping people to continue to live in the community. It provides care to people who may for a short time require more intensive treatment or therapy which cannot be given at home. It also enables the carer to have a break during times when for various reasons s/he is unable to cope or simply requires a break.

3.14 Currently there are only about 30 designated respite care places available for people with physical disabilities. On average about 10 people would avail of each respite place in the course of a year, so that current provision can cater for approximately 300 people. In its report on respite care, Disability

Federation of Ireland (DFI) states that it has identified a further 837 people with a physical disability who have an immediate need of respite care. This indicates a need for an additional 80 respite care places. However improvements in home care and day care facilities along the lines that we have recommended may reduce the demand for respite care.

3.15 We recommend that as an immediate step towards meeting the need for respite care, health boards should arrange for the provision of respite care places in nursing homes or other suitable locations which are properly equipped and staffed. We estimate that additional expenditure of £400,000 in a full year would provide an additional 40 places benefiting some 400 people. We are satisfied that this is a cost effective way of providing such care in the short-term and is the minimum improvement that is required irrespective of improvements to home and day care recommended above. The immediate priority should be to provide respite care in areas where none currently exist.

3.16 In the longer term, purpose built respite care facilities will be required and we will consider this in our final report.

Community Based Therapy Services

3.17 Community based physiotherapy and occupational therapy services are considerably underdeveloped and where they exist, are mainly focused on providing services for the elderly. The demand for these services for people with physical or sensory disability is increasing and needs to be addressed.

3.18 Community based therapy services comprise two distinct but complementary elements - a domiciliary service and a service based at a clinic or centre. A domiciliary based occupational therapy service, providing advice and guidance on the use of technical aids and appliances, can significantly assist independent living. While we consider that physiotherapy can be provided more efficiently in properly equipped and locally based therapy centres and hospitals there is also a need for a domiciliary based service. Of crucial importance

however is the need for an improved follow-up service between hospital and community based service to ensure that when people with disabilities are discharged from hospital they continue to receive adequate therapy service.

3.19 There are also serious delays in the provision of speech therapy at present. We appreciate that there are difficulties in the recruitment of speech therapists and welcome the action of the Minister for Health in increasing the annual intake to the School of Clinical Speech and Language Studies from 20 to 26 which will in the medium to long-term significantly improve the availability of trained staff. There is a similar need to increase educational resources in other therapy professions.

3.20 We consider that as an initial step an additional 50 therapists in the different disciplines should be provided. Recruitment of these should begin immediately. Their deployment would be a matter for health boards in consultation with voluntary organisations. The cost in a full year is estimated at £1m. Approximately 12,000 people would benefit from such an expansion in the service.

Technical Aids and Appliances

3.21 With modern technology there is now a wide range of equipment available to assist disabled people. These developments can make a significant contribution to independent living but if advances in technology are to be exploited to the full it is essential that disabled people are in a position to avail of them.

3.22 There is currently a serious lack of resources to fund the purchase of even basic appliances, such as electric wheelchairs. There are also significant delays in the supply of such items. In addition there is a lack of resources for the repair of equipment and delays occur in the repair of technical aids. We recommend that an additional £250,000 be made available on an ongoing basis to improve the availability of equipment and reduce waiting time for the supply

and repair of necessary equipment. In our view priority should be given to the supply of basic medical and surgical appliances. However resources should also be made available to assist people with the purchase of technical aids to assist independent living. It is estimated that approximately 1,000 would benefit from this investment.

3.23 The National Rehabilitation Board will have a national technical aids advice service in its new centre at North Great George's Street Dublin from early 1993. While we welcome this development there is a need to make this service more locally accessible to those who need it. NRB, health boards and relevant voluntary bodies should discuss the most cost-effective way of achieving this objective.

Residential Care

3.24 In Chapter IV we outline the urgent need for additional residential accommodation for people with physical disabilities and recommend that planning commence immediately on the provision of purpose-built residential facilities.

3.25 Pending the availability of purpose-built facilities we recommend that in order to meet the immediate need for residential facilities health boards should examine the possibility of providing residential accommodation in specially dedicated units in existing hospitals. These could be located in district or geriatric hospitals. The atmosphere in these units should be home-like rather than institutional with the residents having the greatest degree of independence possible. The question of placements in suitable nursing homes should also be examined. We recommend that £500,000 should be allocated to adapt and improve existing premises in order to make them suitable for people with physical or sensory disability. Such facilities could provide a mix of residential and respite care.

3.26 New residential developments at Sligo and Letterkenny are virtually

complete. These are the only residential developments currently taking place. Given the urgent need for residential care we recommend that the 1993 revenue costs estimated at £150,000, be made available in 1993. The question of planning for urgently required residential care for people with physical disabilities is dealt with in Chapter IV

Funding of Voluntary Bodies

3.27 We are aware that many voluntary bodies have incurred substantial deficits in the development of services for their clients. In addition there is undue emphasis on the use of short term labour supply mechanisms, e.g. FAS schemes, and this has led to intermittent provision due to insecurity of funding. A number of organisations, both statutory and voluntary, have been affected in this way.

3.28 As in other parts of the voluntary sector, the level of staffing and pay rates do not always reflect established standards. The use of unpaid volunteers has camouflaged the extent of this issue. Continued reliance on these volunteers cannot be assumed and a start must be made to ameliorate the most significant gaps in staffing and to remedy the serious disparity in pay rates which is already causing industrial relations problems for a number of organisations. This is not to imply that the involvement of voluntary effort has no place in the modern-day service. On the contrary it should be nurtured and encouraged and given every opportunity to continue its unique contribution; but reliance on purely volunteer support for core service provision is not a viable long term option.

3.29 We consider that an initial injection of £1m is required to redress the current funding deficits, staffing shortages and disparity in pay rates in the voluntary sector.

Sign Language Interpretation

3.30 There is an acute shortage of sign language interpreters to assist deaf and

deaf-blind people in communicating with the hearing population. This creates special difficulties for people with hearing impairments in coping with employment interviews, medical and dental appointments, local authority and health board appointments, parent-teacher meetings, legal and financial affairs, court appearances and a wide range of other activities which are taken for granted by the rest of society. Additional funds are urgently required to begin to tackle this shortage. We recommend that £50,000 be set aside for the training of sign language interpreters.

Driver Training

3.31 The use of a private car is of particular benefit to people with physical disabilities and, in many instances is the essential link with community life, employment, leisure etc. It greatly reduces social isolation and dependency on services. The demand for driver training is considerable and additional support for this service, essential to independent living, is urgently required. We recommend that an additional sum of £30,000 be allocated in 1993.

Transport

3.32 While there are various tax concessions available to help some severely disabled drivers, the cost of acquiring a first car can be prohibitive especially for people on low incomes. In rural areas where there is no public transport available the provision of a car can help to reduce social isolation and enable a disabled person to travel to work and training. The Motorised Transport Grant of £1,500 payable by the health boards which, when introduced, was of considerable benefit in acquiring a first car, has not been increased for a number of years. There is, therefore, an urgent need to increase the allowance to a more realistic level of £2,500. The cost of this improvement is estimated at £50,000 in a full year.

Income Maintenance

3.33 The ability of people with physical or sensory disability to live independently in the community requires not only adequate personal support

services but also adequate income support. The need for an integrated structure for all income support services has been referred to in a number of official reports. The Commission on Social Welfare recommended that responsibility for the administration of three schemes (Disabled Persons Maintenance Allowance, Blind Welfare Allowance and Infectious Diseases Maintenance Allowance) whose primary purpose was to provide income maintenance should be transferred to the Department of Social Welfare. It suggested that other cash allowances which serve a community care function should continue to be administered by the Department of Health and health boards. These schemes include the Domiciliary Care Allowance, Motorised Transport Grant and the Mobility Allowance.

3.34 We fully support the recommendations of the Commission on Social Welfare which were subsequently endorsed by the Commission on Health Funding. We consider that these should be implemented as a matter of urgency. Centralisation of income maintenance schemes in the Department of Social Welfare would lead to a more consistent approach to the definition of need and to greater uniformity in the assessment of means and the determination of eligibility. Recent changes in legislation and regulations governing the operation of Health and Social Welfare schemes, particularly in relation to equal treatment and overlapping payment provisions require full co-ordination between the various schemes. The absence of a central administration leads to unnecessary duplication of effort and can lead to delays in processing applications. We will consider this issue further in our final report.

Summary

3.35 The following table gives a summary of our recommendations in regard to meeting urgent needs which can be quickly implemented.

Summary of urgent needs capable of being implemented quickly

Service	Numbers to benefit	Capital Costs	Revenue Costs
1. Home Care	800		1,050,000
2. School Support	150		100,000
3. Day care	200	500,000	250,000
4. Respite Care	400		400,000
5. Community based therapy	12,000		1,000,000
6. Technical Aids & Appliances	1,000		250,000
7. Residential Care	20	500,000	150,000
8. Funding of Voluntary Bodies	200		1,000,000
9. Sign Language Training	200		50,000
10. Driver Training	100		30,000
11. Transport	100		50,000
TOTALS		1,000,000	4,330,000

Chapter IV

Urgent Planning Requirements

4.1 As indicated in Chapter II we consider that there is a need to commence planning now on a number of developments in advance of our final report. These are detailed in the following paragraphs and are set at a level which we feel will be well within the limits of any final recommendations we are likely to make. The table at paragraph 4.8 details financial implications of planning commencing in 1993 on these developments.

Residential Care

4.2 Our preliminary examination of the residential care requirements of people with physical and sensory disabilities indicates a need for accommodation providing different levels of care -

(i) independent living facilities with appropriate back-up services. Such accommodation should more appropriately be provided by the housing authorities. The provision of support services such as home help or care assistants etc. would be a matter for the health services;

(ii) residential care facilities for those who cannot live at home and who require support of the type currently provided in Cheshire Homes;

(iii) accommodation for those with behaviourial problems who would require significant support services;

(iv) special units providing a high level of both medical and nursing care. Such units would cater for people with severe disabilities such as serious brain damage, stroke victims etc.

4.3 Our detailed examination of the residential care needs will also consider other issues such as -

(i) the quality of existing facilities and the possibility of adapting these to provide suitable accommodation;

(ii) the appropriate size of residential units;

(iii) the long-term residential needs of people with severe spinal injuries and neurological conditions.

4.4 At present there are 385 residential places available for people with physical disabilities. Two health board areas, the Midland and the North Eastern, have no residential care facilities specifically for people with physical disabilities. The following table outlines the present provision :-

Health Board	Cheshire Homes		Other Homes		Total Places
	No's	Places	No's	Places	
Eastern	4	107	3	101	208
Midland	-	-	-	-	-
Mid-Western	1	29	-	-	29
North Eastern	-	-	-	-	-
North Western	2*	20	-	-	20
South Eastern	1	24	-	-	24
Southern	1	28	-	-	28
Western	2	76	-	-	76
Total No. of Places					385

* To come on stream in 1993

4.5 An indication of the need for residential care can be gauged from the following:-

(a) the Eastern Health Board has identified 95 persons in need of long-term residential care. Fifty four of these are currently in acute hospital beds; sixteen are being cared for in the community with the remaining 25 inappropriately placed in other institutions;

(b) a recent survey by the Western Health Board of the service needs of physically handicapped adults in its area showed that some 25 persons would benefit from the provision of residential care services;

(c) a similar survey by the South Eastern Health Board found 16 physically disabled people living in either geriatric or district hospitals, at least 14 of whom would be more appropriately placed in small units specifically designed for young people with disabilities. In addition it identified a further 9 people living in the community who require residential care.

4.6 It should, of course be borne in mind that the above assessments of need were made in the absence of adequate community based supports. As indicated in paragraph 2.3, where such supports are in place the demand for residential care can be reduced. However, given the current waiting lists for residential care and the scale of inappropriate placements, we consider that there is an urgent need to commence planning on at least four 20-place residential care units. This is well within the bounds of the level of residential care provision that will be required in the long-term.

Respite Care

4.7 In paragraph 3.15 we recommend that as an urgent response to the need for respite care, health boards arrange for the provision of respite care places in nursing homes or other suitable locations. In the longer term there is a need for purpose built respite care facilities. We consider that planning should commence immediately on four 10-place respite care centres.

Financial Implications of Urgent Planning Requirements

4.8 The following table details the estimated cost of planning commencing now on the provision of the residential and respite care places recommended in the preceding paragraphs. We are satisfied that our recommendations in relation to the planning of residential and respite care are minimum urgent requirements which will be necessary irrespective of any improvements in primary care supports.

Service	Capital cost 1993*	Capital cost in future years	Total Capital Cost	Annual Revenue Cost on completion
	£m	£m	£m	£m
Four 20-place Residential Care Units	0.2	6.0	6.2	1.5
Four 10-place Respite Care Centres	0.1	4.0	4.1	1.0
Total	0.3	10.0	10.3	2.5

* Only planning fees will arise in 1993

Sheltered work/employment

4.9 Sheltered work places are currently available in long-term training centres, sheltered workshops, and in the industrial therapy and occupational therapy units of psychiatric hospitals. It is generally agreed that these facilities do not meet current need, either in terms of the number of places available or of work options offered. The provision and funding of sheltered work/employment for people with disabilities is an issue which needs to be addressed. As it is an issue which concerns all categories of disability and is a subject which requires an in-depth examination, we recommend that it be the subject of a separate examination as a matter of urgency.

Concluding Comment

We wish to stress once again that while we have a clear view as to the general policy which should underpin the development of services, we have only been able to make a very preliminary assessment as to the future arrangements in relation to the provision of health care services to people with physical and sensory disabilities. Likewise we have been able only to make tentative estimates as to the appropriate mix and level of services which should be made available in the longer term. We are satisfied, however, that the recommendations which we have outlined in this Interim Report are well within the parameters of ultimate service needs and within reasonable cost limits. We are also satisfied that the provision of the services set out here will make a significant contribution towards meeting the immediate health care needs of persons with a physical and sensory disability and will lay a sound foundation for the further development and strengthening of services in the future.

Appendix I

OVERALL FINANCIAL IMPLICATIONS OF REVIEW GROUP RECOMMENDATIONS

	1993 Costs			Capital cost in future years	Annual revenue costs on completion of capital developments
	Revenue	Capital	Total		
	£m	£m	£m	£m	£m
Urgent Requirements	4.33	1.00	5.33	-	1.50
Planning Requirements	-	0.30	0.30	10.00	1.00
Totals	4.33	1.30	5.63	10.00	2.50

Appendix II

Bodies invited to make submissions

Action for Mobility
Arthritis Foundation
Association of Occupational Therapists of Ireland
Brainwave, Irish Epilepsy Association
Central Remedial Clinic
Cerebral Palsy Ireland (CPI)
Cheshire Foundation
Community Physiotherapists - Eastern Health Board
Disability Federation of Ireland
Disabled Drivers Association
Eastern Health Board
Forum of People with Disabilities
Friedreichs Ataxia Society Ireland
Headway Ireland
Incare Association
Institute of Community Health Nursing
Irish Association for Spina Bifida and Hydrocephalus
Irish Association of Social Workers
Irish Association of Speech & Language Therapists
Irish Council for Social Housing
Irish Deaf Society
Irish Guide Dogs Association
Irish Motor Neurone Disease Association
Irish Nursing Organisation (INO)
Irish Society of Chartered Physiotherapists
Irish Society of Medical Officers of Health
Irish Wheelchair Association
Limerick Handicapped Children Committee
Mary Immaculate School for the Deaf
Midland Health Board
Mid-Western Health Board
Multiple Sclerosis Society of Ireland
Muscular Dystrophy Ireland
National Association for the Deaf
National Association of Home Care Organisers
National Council for the Blind
National League for the Blind
National Medical Rehabilitation Centre
National Rehabilitation Board
North-Eastern Health Board
North-Western Health Board
Rehabilitation Institute
Royal Hospital Donnybrook
RP Ireland - Fighting Blindness
Southern Health Board
South-Eastern Health Board
St Joseph's House for Adult Deaf & Deaf Blind Brewery Road
St Joseph's School for the Deaf
St Joseph's School for Visually Impaired Boys
St Mary's School for Hearing Impaired Children
St Mary's School for the Visually Impaired
Superintendents & Senior Public Health Nurses' Association
Volunteer Stroke Scheme
Western Health Board